frequent urine testing, and their licenses are being held for ransom to ensure compliance. The raw success rate for alcoholics who attempt to recover just by attending AA meetings is a dismal 20% or less.

Dr Joseph Frawley of the Schick-Shadel Institute reports that 60% of the Institute's patients are agnostics or atheists compared to less than 30% of those admitted to AA role programs. Yet Schick's program boasts a recovery rate as high as traditional programs without reliance on AA.

Most nonbelievers who seek recovery at AA must change their beliefs or tolerate the constant barrage of religious rhetoric. Many end up leaving, possibly to die from their disease.

In the California Diversion Program nonbelievers cannot leave because their licenses are at stake. They are subject to critical review by authorities who equate recovery with Alcoholics Anonymous.

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REFERENCE

1. Ikeda R, Pelton C: Diversion programs for impaired physicians, *In* Addiction Medicine (Special Issue). West J Med 1990 May; 152:617-621

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Mr Pelton Responds

To THE EDITOR: Dr Andersen's letter is generally correct. We do embrace AA and the 12 steps of AA. Our experience is that most physicians who develop a strong recovery program have embraced AA.

There are some physicians, however, who are not able to embrace AA. Some physicians, and others as well, have difficulty discovering the distinction between a Higher Power and God. Most physicians are able to identify with the spirituality of a Higher Power rather than the religious aspects of God.

For those physicians who do not believe in God or who cannot relate to a Higher Power, we suggest other meetings such as secular sobriety groups. If the message of sobriety comes through in those meetings, that is where the physician should go.

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There Ought To Be a Law

To THE EDITOR: I read with interest and pleasure the May 1990 issue on *Addiction Medicine.* As a former long-time member of the Medical Board of California, I would like to make some additional comments about the problems of prescription drug abuse[1] and the impaired physician.[2]

With regard to the "duped" physician, I agree with Wesson and Smith that the physician receives too much blame. As a family practitioner, it is not uncommon to be caught in the bind of wanting to minister to someone's pain while suspecting that a hustle is going on. It is often necessary to rigidly limit pain prescriptions, but this leaves bonafide problems untreated. A sensitive physician is often in conflict over this issue. In my opinion it would be helpful if the Board and the California Medical Association would jointly sponsor legislation making it a felony to seek a controlled substance from a licensed prescriber under false pretenses. I do not know of such a law now, and I think it would have a deterring effect on many of the hustlers, most of whom seem to be more middle class and educated than other abusers.

Finally, I think California's impaired physician program deserves the greatest praise for its accomplishments. I do not think the article was detailed enough in pointing out the great amount of integrity and professionalism involved in running a confidential treatment program within a law enforcement agency. This was able to be accomplished under the magnificient leadership of the Board's former chief medical consultant Dr Joseph Cosentino, who recently passed away.

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REFERENCES

1. Wesson DR, Smith DE: Prescription drug abuse—Patient, physician, and cultural responsibilities, *In* Addiction Medicine (Special Issue). West J Med 1990 May; 152:613-616
2. Ikeda R, Pelton C: Diversion programs for impaired physicians, *In* Addiction Medicine (Special Issue). West J Med 1990 May; 152:617-621

CORRECTIONS

The authors have discovered an error in their case report of "Acute Oleander Poisoning—A Suicide Attempt in a Geriatric Patient."[1] The legend for Figure 1, which read "Digoxin serum concentration versus time, in minutes, is shown," should have read "Digoxin serum concentration versus time, in hours, is shown," and the X axis of the graph also should have been labeled "Time, hours."

REFERENCE

1. Driggers DA, Solbrig R, Steiner JD, et al: Acute oleander poisoning—A suicide attempt in a geriatric patient. West J Med 1989 Dec; 151:660-662

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On page 35 of Jenkins et al,[1] the percentage of Vietnamese refugee women who had never had a Papanicolaou test should be 85%, not 89%. The percentage shown in Table 2 is correct. The authors and the journal staff apologize for any confusion caused by this error.

REFERENCE

1. Jenkins CNH, McPhee SJ, Bird JA, et al: Cancer risks and prevention practices among Vietnamese refugees. West J Med 1990 Jul; 153:34-39